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## Waiting for common-law solutions for the most vulnerable populations' healthcare access

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### Résumé

#### Position du problème

L'état de santé des populations est lié à leur accès à des soins de santé de qualité. Réaliser au mieux cette condition principale – sanitaire, sociale et humanitaire – est un objectif permanent de politique publique. Beaucoup d'efforts sont réalisés. Mais intègrent-ils autant qu'il le faudrait l'état de santé des populations les plus vulnérables ? En France, la réduction du phénomène du renoncement à des soins est un axe prioritaire de la politique actuelle de l'Assurance maladie. Dans le cadre des Plans locaux d'accompagnement du non-recours, des incompréhensions et des ruptures (PLANIR), cette institution est en train de généraliser un dispositif d'intervention territorial et partenarial dans le but d'éviter que les assurés sociaux renoncent à des soins. Cet investissement social est sans précédent. Pour autant, l'impact du dispositif sur les populations les plus vulnérables paraît limité pour le moment.

#### Méthode

L'examen de cet exemple repose sur le suivi de la généralisation du dispositif en question. Ce suivi a été confié à l'équipe de recherche cofondée par l'auteur (l'Observatoire des non-recours aux droits et services). Il comprend quatre volets : suivi quantitatif de la détection et du traitement des situations de non-recours (n = 160 000 questionnaires), analyse des résultats par entretiens qualitatifs auprès de bénéficiaires et de personnes ayant refusé le dispositif (n = 365 entretiens), analyse de la mise en œuvre par entretiens qualitatifs et observations participantes auprès des services chargés de la mise en œuvre (n = 18 entretiens collectifs sur trois sites), analyse du partenariat par entretiens collectifs avec l'ensemble des acteurs des territoires engagés dans le dispositif (3 sites).

#### Résultats

L'analyse montre que l'intégration de l'état de santé des plus vulnérables dans un dispositif d'intervention de droit commun dépend de trois limites : la neutralité du dispositif face aux décisions et non décisions publiques qui creusent les inégalités sociales et territoriales de santé ; son design organisationnel qui n'intègre pas la nécessité d'une intervention médico-psycho-sociale du temps long ; l'absence d'une régulation capable de rapprocher et de coordonner les acteurs qui agissent au local pour l'accès aux soins de santé mais pour des populations différentes.

#### Conclusion

Les difficultés pour intégrer les plus vulnérables dans un dispositif de droit commun comme celui proposé par l'Assurance maladie ne paraissent pas insurmontables. Mais à la condition que l'autorité de régulation (les Agences régionales de santé) ait la volonté et la possibilité d'en faire un objectif stratégique organisationnel au plan local.

#### Mots clés

Accès aux soins. Populations vulnérables. Dispositifs de droit commun. Assurance maladie. Urgence sociale.

## **Abstract**

### **Background**

The state of populations' health is linked to their access to quality healthcare. Best achieving this primary condition – a health, social and humanitarian condition – is an ongoing public policy objective. Although significant effort goes into this, do public policies sufficiently take into account the state of health of the most vulnerable populations? In France, reducing the non-take-up (NTU) of healthcare is a priority in current national health insurance policy. Under the local plans to tackle non-take-up, lack of understanding and exit from the system<sup>1</sup>, national health insurance is currently rolling out a regional and partnership-based intervention framework in order to prevent NTU of healthcare by welfare clients. This social investment is unprecedented, yet the impact of the framework on the most vulnerable populations still seems to be limited.

### **Method**

The study of this example is based on monitoring of the framework's general implementation. This task was entrusted to the research team co-founded by the author, ODENORE<sup>2</sup>. It is organized in four parts: quantitative monitoring of the detection and addressing of non-take-up situations (n = 160,000 questionnaires); analysis of the results through qualitative interviews with beneficiaries and individuals who rejected the framework (n = 365 interviews); analysis of the framework's implementation, using qualitative interviews and participant observations at the services in charge of the framework's implementation (n = 18 collective interviews across three sites), and an analysis of the partnership through collective interviews with all the actors in the areas involved in the framework (three sites).

### **Results**

The analysis shows that the integration of the most vulnerable populations' state of health into a common-law framework for intervention is hindered by three limitations: the framework's neutrality regarding public decisions and non-decisions that exacerbate social and regional health inequalities; its organizational design, which does not take into account the need for long-term medical-psycho-social care; and the absence of regulation capable of bringing together and coordinating the actors working towards healthcare access locally but with different populations.

### **Conclusion**

The difficulties of integrating the most vulnerable populations into a common law framework such as the one proposed by the national health insurance do not seem insurmountable – provided, that is, that the regulatory authority (the regional health agencies) are willing and able to make it a strategic organizational objective at local level.

### **Key words**

Healthcare access. Vulnerable populations. Common law framework. Health insurance. Social emergency.

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<sup>1</sup> PLANIR, *Plans locaux d'accompagnement du non-recours, des incompréhensions et des ruptures*

<sup>2</sup> *Observatoire des non-recours aux droits et services* - Observatory for the Non-take-up of Social Rights and Public Services

## Introduction

There are many determinants of the state of populations' health, and access to quality healthcare is one of the main factors. Best achieving this is an ongoing public policy objective. Although substantial effort goes into it, does public policy sufficiently take into account the state of health of the most vulnerable populations? In France, reducing non-take-up (NTU) of healthcare is a priority within the current national health insurance policy. As part of the local plans to tackle non-take-up, lack of understanding and exit from the system (PLANIR)<sup>3</sup>, the national health insurance is currently rolling out a local and partnership-based intervention framework t. This social investment is unprecedented. For the time being, however, the solutions offered by the framework are not (or very poorly) geared towards the most vulnerable populations. The analysis of this example shows that integrating the most vulnerable populations' state of health into a common-law intervention framework is hindered by three limitations: the framework's neutrality regarding public decisions and non-decisions that exacerbate social and regional health inequalities; its organizational design, which does not take into account the need for long-term medical-psycho-social care; and the absence of regulation capable of bringing together and coordinating the actors working towards healthcare access locally but with different populations. Ultimately, such difficulties raise questions about the transformation of the social welfare model.

### **Healthcare access: availability, accessibility, acceptability**

The links between the most vulnerable populations' state of health and healthcare access have long been of concern. Internationally, many research reports and expert reports have reiterated that strong health and health insurance systems improve the state of health of the entire population and especially of those with insufficient access to care (1-2-3). In France, this is also an on-going issue (4-5).

These reports draw on ample evidence that the poor state of health of the most vulnerable populations is due to non-existent or insufficient access to quality care. Access to healthcare is thus a crucial issue that the international literature mainly associates with four types of difficulties to explain the poor health of impoverished populations or those most vulnerable. These difficulties stem from the lack of healthcare provision, or even the absence thereof. They also reflect barriers that may be financial, organizational or geographical, or social and cultural (6-7). The article by Roy Penchansky and J. William Thomas on the concept of access in health policy was a landmark (8). It effected a shift from a conception of access as the introduction or use of a healthcare offer to a taxonomic definition that posits access as a general concept synthesizing a set of more specific dimensions describing the adequacy of the healthcare and health insurance systems in relation to patients' needs. Subsequently, other dimensions were introduced, such as individuals' awareness of their own needs, (9) that harsh living conditions can impede (10). This approach has contributed towards a connection being made, in the analysis of social and regional health inequalities, to the various difficulties that individuals face with regard to the healthcare and health insurance systems and – the two are related – to the country's level of development and the living conditions it affords. The forms and extent of difficulties to access quality healthcare vary considerably from one country to another. These types of difficulties are

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<sup>3</sup> PLANIR, *Plans locaux d'accompagnement du non-recours, des incompréhensions et des ruptures*

nevertheless useful general indicators (at least in developed countries, and peaceful countries at that) to study healthcare access – which can be measured in terms of NTU of healthcare (self-reported) or non-take-up (medically proven) (11) – as the result of healthcare availability, its geographical and financial accessibility, and the acceptability of services (12).

The issue of the actions needed to try to remove these obstacles is therefore crucial. It is framed in sometimes similar terms, irrespective of the country or continent. Beyond the enormous disparities between policies or programmes, there are similarities, if not sameness, between the solutions sought in very different contexts. For example, the “*mutuelles communales*” that exist in over 1,750 French municipalities seem quite similar to community-based health insurance (CBHI) programmes developed in low- and middle-income countries (13). In both cases, a mutual benefit principle applies, even if the contractual arrangements necessarily differ (in particular, the abolition of insurance premiums for the most disadvantaged, which is one of the strengths of CBHI programmes).

Without denying the progress made, much remains to be done, irrespective of the situation of the country studied. Here again, from one study or expert report to another, the finding is the same finding: there is a need for mass-scale and sustainable action plans to improve healthcare access for the most vulnerable populations. Clearly, the question of how to fund policies or programmes is crucial. It largely hinges on countries’ or continents’ political stability and wealth; health is thus a geopolitical issue (14). However, even in wealthier countries, the sustainability of responses is central to removing or preventing some of the difficulties (insufficient healthcare offer, and financial or geographical inaccessibility). But it is also about formulating appropriate responses – that both meet the needs of and are acceptable to recipients – in order to remove obstacles, particularly those related to social or cultural factors. The question then becomes whether the policies or programmes proposed to facilitate access to care are equally concerned with the state of health of the most vulnerable populations – in other words, whether they are designed in a way that takes their specific difficulties into account. As we know, the absolutely essential development or maintenance of health and health insurance systems does not necessarily reduce social and regional health inequalities. Far from it. To improve healthcare access, it is also necessary to remove demand-related barriers (15), that is, to provide frameworks that are not only accessible but also acceptable to their recipients.

The suitability of the solutions offered therefore also appears to be a crucial factor to consider. Generally speaking, it contributes significantly to non-take-up, irrespective of the frameworks or populations (16). The question of suitability can thus be raised, as we do here, in the context of recent national health insurance policy developments designed to improve access to care and health. For several years now, one of the national health insurance’s objectives has been to curb the NTU reported by 25% of welfare clients who visit national health insurance centres (CPAMs)<sup>4</sup>, or who are covered by one of the branches of the national health insurance fund, based on thresholds set by the institution (17). With an average 26 million welfare clients visiting these centres every year (out of the total 61.5 million welfare clients overall<sup>i</sup>, as well as contributors to the former social security scheme for the self-employed (RSI)<sup>5</sup>) as of 1 January 2018), this brings the estimated number of welfare clients who did not take up healthcare to nearly 8 million in the

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<sup>4</sup> *Caisses Primaires d’Assurance Maladie*

<sup>5</sup> *Régime social des indépendants*

past year. The question is whether this policy also targets the most vulnerable, namely the 8 million people with the lowest standard of living<sup>ii</sup> (some of whom may be welfare clients). To answer this question, we consider the flagship framework of this policy, to discuss which solutions can and cannot remove the different types of barriers that make healthcare access a public issue.

### **A health insurance framework to improve healthcare access**

This framework is known as a PFIDASS<sup>6</sup>, that is, a *département*-level intervention platform for access to healthcare. It was created specifically to address NTU of healthcare. The initiative, designed and spearheaded by a few CPAM directors, has become one of the national health insurance fund's institutional commitments. The general implementation of this framework is enshrined in the new objectives and management agreement (COG)<sup>7</sup>, signed with the State for the 2018-2022 period. The story of this innovation was presented as follows by its main artisan (18). According to him, what makes this "social investment by the national health insurance" all the more commendable, is that the project is so surprising. The researcher working with the national health insurance to analyse the general implementation of the framework has shown that the close intertwining of risk management and fighting fraud within the institution left little room for such an initiative, and then explains how it was finally able to take shape and to spread (19-20).

The purpose of the framework is to provide the care that is lacking and then to keep the individuals concerned in optimal care pathways. To this end, the administrative, social and medical services of the national health insurance are mobilized to implement a three-tiered intervention: (a) detect situations of NTU and get the individuals concerned interested in the framework; (b) assess all rights to social benefits and, depending on the situation, grant the right to free or subsidized complementary health insurance (or check that the insurance taken out by each individual is suited to their needs), as well as checking whether the individual has registered with a doctor to ensure better coverage of health expenses as part of a coordinated care pathway; and (c) help individuals find quality care from health professionals at the best price, and if necessary leverage different social funds for welfare clients unable to cover out-of-pocket costs. This framework, first developed at local level, gradually spread and is now implemented by the health insurance funds themselves. Each fund can tailor the model, not only to best integrate the changes induced in practices, but also to establish local partnerships (often through bilateral agreements) with different public and private actors (local authorities, municipal and inter-municipal welfare outreach centres, local social integration centres, public service centres, non-profits, complementary health insurance organizations, psychological medical centres, etc.). These partnerships are necessary to "externally" detect NTU in parallel and to collectively formulating responses on a case-by-case basis, with a "win-win" approach. The partners support the CPAMS' work and also benefit: situations in which they cannot or do not know how to intervene are handled, thanks to PFIDASS advice, mediation and funds; social work is bolstered: at local level, PFIDASS is an "additional solution" that lends credibility (or restores it) to certain partners' work, without the framework scattering or hijacking their audience; their own legitimacy as local actors is reinforced, etc. In return, CPAMs find partners for detection, care

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<sup>6</sup> *Plateforme d'intervention départementale pour l'accès aux soins et à la santé*

<sup>7</sup> *Convention d'objectifs et de gestion*

support, or even funding to cover out-of-pocket costs where needed, and access to health professionals.

CPAMs alone cannot solve everything; partnerships are therefore essential. The funds recognized this from the start of the process when they discovered the extent of NTU of healthcare. This demonstration of realism was decisive, as very early on it led the precursor funds to turn to the local and regional actors with which they were already collaborating to pitch their project and offer their resources. As the aim was to build the framework on a partnership basis, from the outset the question of the population affected was raised, The CPAMs, as contracting authorities, did not however attempt to address it straight away. They merely emphasised the novel and experimental nature of the initiative, which was enough to create consent. With hindsight, one can thus say that the question of the population affected by the PFIDASSs was raised straight away, but not immediately addressed. The national health insurance's desire to provide a rapid response to the difficulties encountered by social welfare clients seeking treatment may have contributed to limiting discussions with partners regarding the population affected.

Before returning to the core question of the most vulnerable populations' access to a framework designed for social welfare clients, it should be noted that the partnership proposed by the PFIDASSs generated immediate interest.

### **A framework built on a cooperative partnership**

From the outside, the national health insurance initiative has been hailed as innovative and important. It is unanimously accepted as a major and exemplary commitment in the fight against non-take-up and for access to rights and services. The report of the High Council for equality between women and men on "Health and access to care", among others, presents the framework and its benefits at length (21), and the 2016 report of the Médecins du Monde observatory of access to healthcare "welcomes the project of generalizing the new framework set up by the CNAMTS to combat NTU of healthcare" (22: 63).

The general implementation of the framework will be completed in July 2019. It is therefore not yet possible to report on its effects. We can however note several observations regarding the obstacles to healthcare access that this framework can remove, in order to examine its relevance for the most vulnerable populations. By virtue of their structure, PFIDASSs can offer several significant benefits to remove various barriers, be they financial or organizational, social or cultural. These are outlined here, and will probably be taken into account in the forthcoming evaluation of the framework.

Notwithstanding the fact that individuals detected as being in a situation of NTU of healthcare may refuse the assistance offered by the framework, PFIDASSs are primarily designed to solve several difficulties. Staff recruited internally are hired for their skills, on a voluntary basis, to work within a framework that needs to be set up from scratch. "PFIDASS counsellors" are responsible for supporting welfare clients until the missing care has actually been provided. This local work is carried out over an average period of three to four months. It helps people to express their difficulties at different levels with a certain level of detail, and to see a way of starting to overcome them, often even a way out of their isolation vis-à-vis public administrations and

services. In this way, social or cultural barriers (one could add psychological barriers) are lifted as unexpected, discreet and effective support is provided. At the same time, this intervention tackles other difficulties when the social workers, who must create their own toolkit (social welfare repertoire; lists of local contacts; notes on each intervention, in addition to computerized reports), mobilize partners to consolidate social support or to ensure that out-of-pocket costs are covered. In these cases, PFIDASS counsellors facilitate administrative access in such a way that the usual barriers disappear, at least for a while. In the chain of interventions, action on a financial level seeks to remove the barrier of out-of-pocket costs. In this case, the counsellors often work with the medical service of the national health insurance to find the best cost-benefit solution for expensive care (often for dental and eye care, or for surgical procedures), but also to leverage different health and social welfare funds. The organization of almost complete coverage of out-of-pocket costs for the most disadvantaged welfare clients gives rise to consultations between CPAMs and mutual benefit insurance schemes in particular. The “collective” response to minimize out-of-pocket costs could certainly be strengthened, as the involvement of certain actors (whether internal or external to the national health insurance) still varies from one area to another.

This horizontal redistribution is organised around a subsidiarity principle that local actors define among themselves. The national health insurance initiative provides mutual benefit insurance schemes and complementary health insurance organizations with a key argument for using their reserve funds. The reasons for spending this money are legitimate as it contributes to an institutional policy; this avoids internal arbitration once the decision to partner with a PFIDASS has been made. However, the framework proposed by the national health insurance does not impact the markers of equal access to healthcare since the PFIDASSs obviously do not serve a redistribution function. Apart from horizontal redistribution using certain social funds, the framework is necessarily totally neutral in terms of vertical equality. It is worth noting that the French social security model is not involved in the redistribution of income, which is itself very limited since the only socio-fiscal instrument is income tax. On the other hand, and above all – as this is a grievance voiced by various actors –, the framework has no effect (nor intention) vis-à-vis the public choices and non-choices that compound social and regional health inequalities. This is one limitation.

### **Neutrality regarding the structural reasons for social and regional health inequalities**

The reactions of major national non-profit networks to the presentation by the Minister of Solidarity and Health, on 13 October 2017, of the Plan to “Improve local and regional access to care”, are telling. These reactions clearly indicate the governmental decisions and non-decisions in the face of which action frameworks such as PFIDASSs are necessarily powerless. The national inter-federal union of health and social welfare charities and private non-profits, which represents 75% of non-profit actors in the health, social and medico-social field, formulated the proposals set out below in response to the Government Plan (23). These proposals aim to remove, in part, the various barriers to healthcare access:

- Financial barriers, through the general implementation of direct payments by insurers (postponed); by maintaining the cap on hospital fees (which are increasing); by limiting the amount not covered by the basic compulsory health insurance for consultations, etc.



- Organisational barriers, by increasing the number of beds or therapeutic apartments for people in precarious situations affected by chronic disabling pathologies and articulating these with general-practitioner and hospital care to ensure continuity in care pathways; by providing 24-hour care centres (PASS<sup>8</sup>) across the entire country (in particular dental, psychiatric, eye care, paediatric and mobile PASSs, but also outpatient or general-practitioner PASSs); etc.
- Lifting cultural barriers by increasing the language interpreting budget allocated to the Regional Health Agencies (ARS<sup>9</sup>) for healthcare professionals and organizations caring for allophone migrants, opening it up to other actors such as PASSs or welcome and guidance centres (CAO<sup>10</sup>), etc.

This partial list highlights some of the issues facing healthcare access for the most vulnerable populations, which PFIDASSs leave unaddressed. It sheds light on the fact that this social investment by the national health insurance does not involve structural adjustment. The aim is visibly not to transform the socio-economic organization of the healthcare and health insurance system, but – and this is nonetheless definitely progress in health and social welfare – to improve healthcare access. Through PFIDASSs (other national health insurance initiatives and regulatory changes should also be taken into account), the national health insurance response is therefore an important part of a “compensation policy” designed to support a general population that has given up on healthcare, but it remains a spectator to reforms and non-reforms. However, the evaluation of PFIDASSs will certainly note their possible profound effects on the social welfare organization itself, such that on different levels they may have a structural effect on the institution:

- In terms of the reputation of the national health insurance, by reasserting its position as a major player in the health sector.
- In terms of the legitimacy of the funds, by giving them greater power to call on and mobilize local actors.
- In terms of the funds’ professional and organizational culture, by upholding support towards healthcare as the shared matrix for all services and professions involved.

In this context, the recent announcement of a possible 100% reimbursement of dental care, glasses and hearing aids could be a game changer. If measures of this kind seek to provide comprehensive responses – in this case financial –, it is worth considering whether PFIDASSs could not be called upon more to better take into account the most vulnerable populations’ difficulties in accessing healthcare and health. Supporting this is the tacit model of primary or secondary intervention that is gradually taking shape at local level. A distribution of labour is emerging across different regions, which tends to leave PFIDASS counsellors primacy in tackling difficulties in healthcare access affecting the least precarious groups, while other actors primarily support those most disadvantaged (primarily to direct them towards the CPAMs). Generally speaking, the more external actors from diverse backgrounds are involved in detecting situations of NTU, the more they are able to turn to PFIDASS counsellors for cases concerning people in highly precarious situations who do not go to CPAM centres. The framework’s impact, however, may not

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<sup>8</sup> *Permanence d'accès aux soins*

<sup>9</sup> *Agences régionales de santé*

<sup>10</sup> *Centres d'accueil et d'orientation*

be as immediate as for other populations, as these individuals require long-term support. This is a second limitation of the framework, which stems from its organizational design.

### **A framework that does not take into account the need for long-term intervention**

Depending on the region, CPAMs' local partners are more or less emphatic about the need to integrate populations facing high levels of precariousness or exclusion: migrant or refugee populations, in particular, and more generally other populations in highly precarious situations, who survive on social emergency measures. Expectations focus primarily on the idea of "outreach PFIDASSs" that would visit places such as day centres and centres for shelter and social reintegration (CHRS<sup>11</sup>), in order to reach out to welfare clients who have exited the healthcare system, detected by the framework deployed internally within the CPAMs.

If this expectation prevails, it could lead to a tipping point in the framework, so that healthcare access for the most vulnerable populations is more adequately taken into account. In regulatory terms, PFIDASSs are intended for all welfare clients, including eligible foreigners, and the national health insurance has never limited their scope. The PFIDASSs' current functioning, with most detection carried out internally, does not bring the most precarious populations within the scope of the framework, even if the populations supported by these platforms do unquestionably also face serious barriers of access to healthcare. For the time being, the PFIDASSs mainly support those who can be called "the inaudible", i.e. the many people who often experience chronic difficulties, but who nevertheless generally do not seek assistance (24). On the other hand, local PFIDASS partners who would like to do more turn to another population, the "social emergency" population, that is, the most vulnerable (people on the street, young or old, isolated and with no resources, migrants and refugees, people coming out of prison, etc.). Yet the PFIDASSs were not designed to work in the field of social emergency.

First, the current regulations do not allow the PFIDASSs to help foreigners in a precarious situation who are not legally authorized to be in the country and have been residing in France for less than three months. Moreover, healthcare access is not necessarily guaranteed either, even when the conditions of eligibility are met. In fact, this has been a source of controversy. While recognizing the national health insurance initiative as absolutely necessary and commendable, in the above-mentioned report the Médecins du Monde observatory of access to healthcare expressed concern about "the recent social security reform creating the universal health protection (PUMa<sup>12</sup>), which makes access to and the continuity of welfare benefits more difficult for certain categories of foreigners legally resident in the country" (p. 63). In particular, the transfer of the processing of applications for residence permits for healthcare, from the Ministry of Health to the Ministry of Home Affairs, has been criticized (25). While the integration of State medical aid (AME<sup>13</sup>) into the PUMa through access to complementary universal health coverage (CMUC)<sup>14</sup> – proposed for several years now by the general inspectorates of social work and of finance, and the national agency for the protection of citizens' rights – continues to be delayed, the PFIDASSs

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<sup>11</sup> *Centres d'hébergement et de réinsertion sociale*

<sup>12</sup> *Protection universelle maladie*

<sup>13</sup> *Aide médicale d'Etat*

<sup>14</sup> *Couverture maladie universelle Complémentaire*

mission seems to be contingent on the varying conditions applied to the different categories of foreign nationals and the pressures from certain partners.

Second, for the other populations living in highly precarious conditions, the organizational design of the PFIDASSs does not seem appropriate. The difficulties in accessing healthcare that these populations experience are known to the actors who work closest to them: PASSs; mobile medical-social support teams; mobile healthcare teams working with people on the street; psychiatric/"precarious living conditions" liaison teams, which are the interface between social emergency bodies and psychiatric hospital units; therapeutic coordination apartments (ACTs<sup>15</sup>) which facilitate the continuity of care pathways, and so on. These actors collaborate with one another and with social emergency organizations which host and support individuals or families in highly precarious situations, such as CHRSS. Faced with individuals in situations of real abandonment due to a deterioration of their living conditions and their psychological state, the main observation repeatedly voiced by these networks of actors is that with this highly diverse population, access to healthcare and health requires the tools of a "bio-psycho-social" clinical approach in order to make individuals reunite with themselves and with their environment. This is precisely what Médecins du Monde pointed out recently (26): a bio-psycho-social clinical approach does not simply involve the provision of care at a set time, but a long-term medical-psycho-social intervention, necessarily on a partnership basis.

The current functioning of PFIDASSs is designed for a general population, to provide the missing care as quickly and comprehensively as possible in order to place people in (or return them to) optimal care pathways in a sustainable way. This work relies on an "objective (get care provided)/resources" design that is unsuited to developing an intervention tailored to the state of physical and mental health of the most vulnerable individuals, and to their needs and capabilities. In fact, the need to integrate populations in highly precarious situations has not yet made its way to the national health insurance fund. The fund has other priorities (zero out-of-pocket costs, integrating the former social security scheme for the self-employed (RSI), developing telemedicine, etc.). Moreover, it certainly has little room to manoeuvre when it comes to some populations' access to healthcare, which falls under the remit of several policies at the same time: public health, the fight against exclusion, but also immigration.

It is nevertheless possible that converging interests may encourage the integration of populations in highly precarious situations, provided that external detection efforts increase. Based on the results of a recent study<sup>iii</sup>, it appears in several respects that, where they exist, local partnerships established by social emergency actors to provide the people they support with access to healthcare could open up the PFIDASSs to cooperation with the shelter and social integration sector<sup>iv</sup>. Partnerships with health actors allow professionals in shelter and social integration organizations to: consolidate their knowledge of psychological or psychiatric problems and thereby be better equipped to report complex situations to PFIDASS counsellors; mobilize networks of health professionals ready to take charge of the coordinated care pathways of people in highly precarious situations, especially when they speak foreign languages; and so on. At the same time, although none of the actors we interviewed were familiar with the driving principle of the PFIDASSs presented during the interviews, they approve of them. They see the benefit of a

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<sup>15</sup> *Appartements de coordination thérapeutique*

partnership with the national health insurance which would strengthen their role as a social referent. They could thus better support people not only to access their welfare benefits but also to access healthcare, as they could inform other professionals that their intervention is part of an initiative spearheaded by the national health insurance fund. Integrating the framework would also allow them to facilitate the search for administrative solutions to open or renew access to welfare benefits. However – and this is a third limitation –, while there is a possibility of converging interests, there also needs to be a firm intention to bring them closer together and the ability to coordinate them. This raises the question of which regulatory authority would be capable of steering and supporting actors all working towards healthcare access, but for different populations.

### **A need for regulation**

The question of regulation seems all the more decisive in the eyes of all local PFIDASS actors, since the State – through the ARSs (regional health agencies) – does not generally contribute when it attends meetings to which it is invited by the CPAMs. As public State institutions, the ARSs, created by the “Hospital, patients, health, territory” law of July 2009, have a degree of autonomy to carry out their missions. As provided for in the law, they are supposed to be authorized to encourage the broadening of the PFIDASSs’ scope to include the most vulnerable populations, thus improving the health system’s efficiency. This will mean strengthening its local anchorage through the adaptation of intervention mechanisms to the needs and particularities of each region. The discreteness of ARSs raises questions, especially since they are required to implement a risk management policy jointly with the CPAMs. The initiative of a few fund directors has thus become one of the actionable objectives of the Objective and Management Agreement signed with the State. It however lacks the general framework of a comprehensive strategy that would make it possible to open PFIDASSs to other actors and other frameworks or approaches, and thereby to increase their impact on populations other than the direct public of CPAMs.

While the creation of ARSs is seen as a success, the limits of their resources and therefore of their regulatory power are nevertheless striking. The issue of resources is of course crucial and just as challenging as the complexity of the health and insurance system. As a result, any desire to act on the state of health of the most vulnerable populations is constrained by a number of realities such as the long-standing crisis in the psychiatric sector, the dramatic long-term drop in resources for health and social support (particularly the number of ACTs), and so on. It is however possible that an egalitarian vision may also be missing from the solidarity model to help frameworks like PFIDASS better integrate the most vulnerable populations (with all the changes involved to integrate a comprehensive and long-term support approach). It is commendable to draw inspiration from systems that manage to continuously improve the quality of initiatives promoting health, healthcare and organisational actions<sup>v</sup>, to entrust ARSs with the three strategic organisational and economic objectives of health and health insurance systems called “Triple Aim” (improving the health of their populations, increasing the quality of their care, and thus achieving better recovery rates, all at a sustainable cost). This does not seem impossible in France. Pierre-Henri Bréchat and Alain Lopez point out that the French Hospital Federation has, for example, integrated these objectives into its set of proposals for 2017-2022 (27). However, this “Triple Aim” does not necessarily provide the foundations for a comprehensive strategy that could help frameworks such as the PFIDASSs reach all populations. It therefore seems necessary

for the regulatory authority to unambiguously reassert that healthcare access for all hinges on the possibility of solutions that are accessible to all. Short of this, the segmented-publics approach will definitely prevail, and instead of remaining a common good, health will definitely become a competitive good.

This type of trend is at play in other fields (education, security, etc.) and to some people it exemplifies the crisis of the egalitarian imaginary (28-29). In the field of health, seeking efficiency to meet organizational and economic strategic objectives is necessary, but it is not enough. There is also a need for strong regulation guided by a clear and assertive social objective for intervention frameworks such as PFIDASSs to be accessible to all, not just to the “inaudible” but also to the “excluded”. The idea is to help the actors driving regulation to evolve towards the shared operational objective of also integrating those most vulnerable. Failing this, the frameworks will remain compartmentalized and the publics segmented, and it will be difficult for ARSs to claim to “act for the health of all” (as their home page proudly states) when the local coordination of the various initiatives will not have been exploited as a source of effectiveness and efficiency. But ARSs are also far from being able to act on everything, and their action depends on structural adjustments to the health system that defy them. One subject of great concern to all PFIDASS actors is that of medical desertification, which undermines the possibility of sufficient access to quality care.

## **Conclusion**

Access to healthcare hinges strongly on the availability, accessibility and acceptability of health and health insurance systems. While action plans help to partially remove barriers, their success is contingent on institutional, organizational and political contexts. The example discussed here shows that wanting to combat the mass phenomenon of NTU of healthcare, however necessary it may be, is not enough to take into account those who do not have direct access to common-law frameworks. The PFIDASS framework should incorporate the need for comprehensive and long-term interventions, which is unusual when dealing with the usual public of CPAMs. Yet there seems to be room for improvement, owing to the possible convergence of expectations and interests between the national health insurance and the shelter and social integration sector, in particular. Working on the front line with the most vulnerable populations, its actors work with many health professionals specialized in healthcare for individuals with the most precarious living conditions. These networks could form important partners for PFIDASSs. Thus, the presence of the regulatory agency is necessary and even expected, unless the PFIDASSs evolve on a case-by-case basis, without articulation to other networks or frameworks. In this case, the conditions of access to healthcare for all will vary from one region to another. There will be nothing resembling a general policy; only an illusion of it will remain. This could also have political consequences. Given the still powerful representation of health as a common good within public opinion<sup>vi</sup>, collective belief in the possibility of solidary and egalitarian solutions could wane further. In this case, the objective of access to rights and social benefits, which is evidenced in many areas, risks being perceived as a lure that serves more to induce a definitive exit from the universalist model of social protection than its necessary transformation.

<sup>i</sup> Accueil du public : l'Assurance maladie se modernise, Ameli.fr, 4 December 2017, available online.

<sup>ii</sup> In France, the poverty rate in terms of living conditions or material deprivation was 11.9% in 2016. It is concentrated among the poorest 20% of the population: this is an alarming sign of social disconnect. These individuals are “unable to cover expenses relating to at least eight of 27 elements considered as desirable, if not necessary, to have an acceptable standard of living”: INSEE, Pauvreté et conditions de vie de 2004 à 2016, Enquête SRCV – Insee Résultats, 2017, available online.

<sup>iii</sup> This study, titled “*Renoncement aux soins des personnes en grande précarité / Accès aux soins et à la santé dans des structures d'accueil et d'insertion sociale*” (“Non-take-up of care by people facing extreme precariousness / Access to care and health in centres for shelter and social integration”), was carried out in 2016-2018 by sociology students from the University of Lille 3, then by students at the *Ecole de Santé Sociale* in south-east Lyon and Valence. I was involved in its management. It was launched by a Hauts-de-France CPAM to further the reflection carried out as part of the implementation of the January 2013 Plan to Combat Poverty and Promote Social Inclusion, and of the Regional Programme for Access to Prevention and Care for the Most Deprived Individuals (PRAPS, *Programme régional d'accès à la prévention et aux soins des personnes les plus démunies*). Funded by this region's directorate for youth, sports and social cohesion and then by that of the Auvergne Rhône-Alpes region, the study was conducted in several areas within different social emergency bodies. Its twofold objective was to characterize the particularities of NTU of healthcare by individuals facing extreme precariousness, and to understand the initiatives of centres for shelter and social integration, in order to facilitate access to care and health for the people they support. Its operational aim was to better situate the possibilities of partnership with actors with whom the CPAMs do not generally collaborate. The survey was based on participant observations, as well as individual and group interviews with supported individuals and social and health professionals and their partners from various healthcare organizations (PASSs, mobile healthcare teams, psychiatric/precariousness liaison teams, etc.).

<sup>iv</sup> The 2008 study “Etablissements sociaux” by the directorate for research, evaluation and statistics (*Direction de la recherche, des études, de l'évaluation et des statistiques*) recorded 827 CHRSS (centres for shelter and social reintegration, *Centres d'hébergement et de réinsertion sociale*), including 360 with an emergency centre.

<sup>v</sup> Pierre-Henri Bréchat and Alain Lopez took the example of Utah and Intermountain Healthcare, a private non-profit health and health insurance system that is a member of the High Value Healthcare Collaborative, a non-profit collective of the country's 19 most virtuous health systems.

<sup>vi</sup> “67% of French people are in favour of health insurance benefiting everyone, irrespective of their social categories or professional status” (p. 42). An equal number “believe that there is no reason to limit spending because health is priceless” (p. 56). “60% believe that public authorities should do more to support the integration of foreigners into our society” (p. 68). “65% believe that the government does not do enough for the poorest” (p. 69), “80% agree that many people do not enjoy the rights or benefits to which they are entitled” (p. 69): DREES, 2008, Barometer of Opinion on Health, Social Protection and Inequality - Main Findings from the 2017 Survey.

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